



PRELIMINARY REPORT OF ALLEGED CHILD ABUSE OR NEGLECT

State Form 114 (R13 / 6-19) / CW 0310
DEPARTMENT OF CHILD SERVICES

Preliminary Report of Alleged Child Abuse or Neglect: In compliance with Indiana Public Law 276, Acts of 1979, IC 31-33-18, the information provided upon completion of this form will be treated as a CONFIDENTIAL RECORD.

Family surname	County	Date of report (<i>month, day, year</i>)	Time of report <input type="checkbox"/> AM <input type="checkbox"/> PM
Name of complainant (<i>and Title / Agency, if applicable</i>)		Telephone number ()	E-mail address
Address (<i>number and street, city, state, and ZIP code</i>)			Forty-five (45) day report required? <input type="checkbox"/> Yes <input type="checkbox"/> No

PARENT / GUARDIAN INFORMATION

Person ID	Name	Role	Date of Birth (<i>month, day, year</i>)	Age	Sex	Race*	Hispanic or Latino Origin?	Address (<i>number and street, city, state, and ZIP code</i>)	Telephone Number
		<input type="checkbox"/> Alleged Perpetrator <input type="checkbox"/> Uninvolved					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Alleged Perpetrator <input type="checkbox"/> Uninvolved					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Alleged Perpetrator <input type="checkbox"/> Uninvolved					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Alleged Perpetrator <input type="checkbox"/> Uninvolved					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Alleged Perpetrator <input type="checkbox"/> Uninvolved					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		

CHILD(REN) INFORMATION

Person ID	Name of Child	Role	Date of Birth (<i>month, day, year</i>)	Age	Sex	Race*	Hispanic or Latino Origin?	Current Location (<i>If other than home</i>)	Report Source Relationship
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
		<input type="checkbox"/> Victim <input type="checkbox"/> Not Involved <input type="checkbox"/> Perpetrator <input type="checkbox"/> Victim / Perpetrator					<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		

ALLEGED PERPETRATOR INFORMATION (If other than parent / guardian)

Person ID	Name	Relationship to Child	Date of Birth (month, day, year)	Age	Sex	Race*	Hispanic or Latino Origin?	Address (number and street, city, state, and ZIP code)	Telephone Number
							<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
							<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		

OTHER PERSON RESPONSIBLE FOR CHILD(REN)

Person ID	Name	Relationship to Child	Date of Birth (month, day, year)	Age	Sex	Race*	Hispanic or Latino Origin?	Address (number and street, city, state, and ZIP code)	Telephone Number
							<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		
							<input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No <input type="checkbox"/> Declined		

*** RACE CODES**

- (AI) American Indian or Alaskan Native** – Having origins in any of the original peoples of North, Central or South America
- (A) Asian** – Having origins in any of the original peoples of the Far East, Southeast Asia, or Indian Subcontinent
- (B) Black or African American** – Having origins in any of the black racial groups of Africa
- (NH) Native Hawaiian or Other Pacific Islander** – Having origins in any of the original peoples of Hawaii, Guam, Samoa or the Pacific Islands
- (W) White** – Having origins in any of the original peoples of Europe, the Middle East, North Africa
- (U) Unable to Determine** – Choose only when client refuses or is unable to identify race(s).

NATURE OF COMPLAINT

Is the child in imminent danger of serious bodily harm? Yes No

If yes, state why. *Request the nature and extent of injury or neglect; if abuse, request where and when the abuse occurred and what part of the body was injured.*

Address directions

Worker safety factors

Report completed by (typed or printed name):

Title

Signature _____ Agency or local DCS office _____ Date (month, day, year) _____

Report assigned to: _____ Date (month, day, year) _____